*LHD name*_____
*LHD address*_____

PEF label

DOCUMENT#: _____

HID/LOC/SITE: _____

INFLUENZA VACCINE ADMINISTRATION RECORD

NAME: _____ **ID/SOCIAL SECURITY#:** _____

ADDRESS: _____
STREET *CITY* *COUNTY* *STATE* *ZIP*

BIRTHDATE: _____/_____/_____ **PHONE NUMBER:**_____
MONTH DAY YEAR

RACE: (Check ONE or MORE) ☐ **(W)** White ☐ **(B)** Black or African American ☐ **(N)** American Indian or Alaska Native*****

☐ **(A)** Asian ☐ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino ☐Yes **or** ☐ No

SEX: (Check ONE) ☐Male ☐Female **How many in HOUSEHOLD:** ___ **Annual INCOME: $**_____ ☐**Income *NOT* Given**

DO YOU HAVE **MEDICAID**? ☐YES***** ☐NO IF YES, **MEDICAID NUMBER**: _____

DO YOU HAVE **MEDICARE**? ☐YES ☐NO IF YES, **MEDICARE NUMBER**: _____

DO YOU HAVE **HEALTH INSURANCE**? ☐YES ☐NO***** IF YES, **COMPANY NAME:** _____

Policy#_____ **Subscriber Name**_____**Group#**_____

YOU or YOUR CHILD ARE LESS THAN 19yrs old AND HAVE HEALTH INSURANCE COVERAGE:

☐ **YES,** the insurance does cover vaccines: ☐ **NO,** the insurance does not cover vaccines ***** **** VFC eligible***

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

"I have read or have had explained to me the information sheet: (Check ONE)
( ) *Inactivated* ***Influenza Vaccine 2015-2016, "What You Need To Know" (VIS Dated 08/07/15)***
( ) ***Live, Intranasal Influenza Vaccine 2015-2016, "What You Need To Know" (VIS Dated 08/07/15)***

I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I request that payment of authorized medical insurance benefits be made to _____ on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

X_____ **DATE:** _____

Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

FOR HEALTH DEPARTMENT USE ONLY **VFC:** ☐ **YES*** ☐ **NO** **FFC:** ☐ **YES** ☐ **NO**

Vaccine Manufacturer:_____**Vaccine Lot Number:**_____**Injection Site:**_____
Signature and Title of Provider: _____ **Provider# :**_____
NOTES: _____ **ICD Code: Z23.** Encounter for immunization

√	INFLUENZA (KVP/VFC under 19yrs *OR* Medicaid covered)	√	INFLUENZA (NON-KVP OR Medicare, Insurance)
	90655 (IIV3) presrv free- ages 6-35 mths		90655NV (IIV3) presrv free- ages 6-35 mths
	90656 (IIV3) presrv free- 3yrs and above		90656NV (IIV3) presrv free- ages 3yrs & above
	90657 (IIV3) ages 6-35 mths		90657NV (IIV3) ages 6-35 mths
	90658 (IIV3) ages 3yrs and above		90658NV (IIV3) ages 3yrs & above *(**Not** Medicare)*
	90661 (ccIIV3) ages 18yrs and above		90661NV (ccIIV3) ages 18yrs and above
	90672 (LAIV4) intranasal, FluMist, ages 2yrs-49yrs		90662 (IIV3) presrv free, high dose, age 65yrs and above
	90685 (IIV4) presrv free- ages 6-35 mths		90672NV ((LAIV4) intranasal, FluMist, ages 2yrs-49yrs
	90686 (IIV4) presrv free- 3yrs and above		90685NV (IIV4) presrv free- 6-35 mths
	90687 (IIV4) ages 6-35 mths		90686NV (IIV4) presrv free- 3yrs and above
	90688 (IIV4) ages 3yrs and above		90687NV (IIV4) ages 6-35 mths
			90688NV (IIV4) ages 3yrs and above

ADMINISTRATION			MEDICARE ONLY		
	G0008 Adm. of Influenza Vaccine				Q2037 Fluvirin
	90471 Adm. of Influenza INJ., Not-Component ☐ 90473 Intranasal		Q2035 Afluria		Q2038 Fluzone
	90460 VFC/not VFC, **by component**		Q2036 Flulaval		Q2039 NOS Flu
	80000 Unspecified Procedure				

Self Pay Only: Amount Collected $_____**Patient Signature X**_____